

# Holistic Approach To Help Sexual Dysfunction

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Received 14 June 2017 ▪ Revised 23 August 2017 ▪ Accepted 24 September 2017

**Abstract:** *Recently, treatment of sexual dysfunction more focused on pharmacotherapy approaches, because of the development of research in the field. With the increasing use of pharmacotherapy, often lead to reduced attention to psychotherapeutic approaches. On the other hand, humans are creatures who respond not only biological but also psychological, social, cultural and spiritual. Handling of sexual dysfunction with holistic approach can provide a complete benefit in the treatment of sexual dysfunction. A psychological approach that can be done to handle sexual dysfunction, so we get a holistic treatment.*

**Keyword:** *sexual dysfunction, holistic approach.*

## INTRODUCTION

Sexual dysfunction often too late to get proper treatment, because people with sexual dysfunction rarely see health services. There are a number of things that cause them to be reluctant to visit health services because they feel embarrassed by the problem that is considered the most secretive, do not know where to disclose, do not understand that sexual function is an illness, many of them do not understand that the disorder can be overcome (Pengkahila, 2003), only 9% want to visit the doctor (Payne and Sadovsky, 2007), in Korea only 2 % men or women discuss their sexual problem with doctor (Moreira, 2006). A study in five countries such as USA, Canada, England, Australia and New Zeland with 631 men and 714 women that have a sexual problem, only 32 % see the medical services (Nicolosi et al., 2006).

There are many kinds of sexual dysfunction in the community. In some studies, found large variation data. The prevalence of sexual function among women 40-45 % and 20-30 % among men with any kinds of dysfunction (Lewiset al., 2004). Some risk factors related to our health state in general, diabetes mellitus, cardiovascular diseases, urogenital diseases, psychiatric problem, the other chronic diseases, and social problem. Premature ejaculation is the most sexual disorders that found in the community, one in 3 men (Pengkahila, 2007), in women, the most frequent is decreased of sexual desire, its 37% (Moreira et al., 2006).

Recently pharmacotherapy for sexual dysfunction is improving so fast, since the phosphodiesterase 5 inhibitor (PDE5i) as a drug for erectile dysfunction, and the many kinds of PDE5i such as tadalafil and vardenafil. This causes a shift in attention to biological problems as a cause of sexual dysfunction. Followed by other studies for other sexual function disorders, such as the use of Selective Serotonin Reuptake Inhibitors (SSRI) as a treatment for disorders of premature ejaculation. This development little forgets that humans are holistic creatures who respond comprehensively both physically, psychologically, socially and even spiritually.

It turns out that this development does not necessarily solve existing sexual dysfunction problems. Although the effectiveness and safety of PDE5i are good, it turns out the dropout is also quite high at around 50% (Althof, 2002). Although erectile repair occurs, sexual intercourse will not necessarily occur, because

sexual intercourse is related to many factors. The use of SSRIs to deal with disorders of premature ejaculation can also cause other problems. It is estimated that around 30% to 50% of SSRI use is associated with sexual dysfunction (Balon, 2006). Paying attention to this seems to be very important to carry out comprehensive therapy so that sexual function can function properly

### Sexual Dysfunction

In households, where there is a conjugal relationship, sexual dysfunction is often related to each other, sexual dysfunction on the part of the husband can cause sexual dysfunction in their partners. A study conducted as part of the Global Study of Sexual Attitudes and Behaviors (GSSAB) in Korea during 2001 and 2002, with 3,691 subjects, found that about 91 percent of men and 71 percent of women had sexual relations during the past 12 months. Premature ejaculation (33%) and erectile dysfunction (32%) are the most common sexual dysfunction in Korean men, and the most common sexual dysfunction found in women is a loss of sexual drive (37%) and inability to orgasm around 31 % (Moreira et al., 2006). Other researchers found that around 64% (16-75%) had problems with the sexual drive, 35% (16-48%) had difficulty orgasm, around 31% (12-64%) had problems with sexual seizures and about 26% (7 - 58%) experience pain (Hayes *et al.*, 2006)

A study to obtain the prevalence and risk factors for sexual dysfunction was carried out in collaboration with urologists with the sexual medicine association, involving more than 200 experts in various disciplines from 60 countries with 17 committees. The result is that the incidence rate of erectile dysfunction is 25-30 thousand per year. The prevalence of sexual dysfunction in women is around 40-45% and 20-30% in men have at least one sexual function disorder. General risks associated with sexual dysfunction in both men and women are general health status, diabetes mellitus, cardiovascular disease, urogenitalia disease, psychiatric or psychological disorders, other chronic diseases and social demographic conditions (Lewiet *et al.*, 2004).

According to the International Consensus Development Conference on Female Sexual Dysfunctions, it is recommended that a group of sexual function disorders in women become four groups of disorders such as sex drive disorders, sexual arousal disorders, orgasm disorders, and sexual pain disorders (Rosen *et al.*, 2000). Whereas in men grouped into four groups namely sex drive disorders, erectile disorders, ejaculation disorders, and orgasm disorders. Sexual drive disorders in the form of a decrease in sexual drive. Erectile disorders are the inability to achieve and maintain an erection in sexual intercourse. Ejaculatory disorders have premature ejaculation, there is late ejaculation and there is retrograde ejaculation, and orgasmic disorders are the inability to reach orgasm.

### Principles in Handling Sexual Dysfunction

In handling sexual dysfunction sexual function must be seen as a function of relations with family, husband, and wife. In this context, sexual disorders in one partner will have an effect on the partner. There are many approach strategies that can be done, but according to Althof, three things must be considered: 1) there are no or only a few psychological obstacles; 2) There are moderate psychological barriers, and 3) there are severe psychological barriers. Of the three groups, therapy can be chosen. For example in the first group with no or few psychological barriers, medical therapy will provide good effectiveness. If the couple has a big obstacle, therapy with medical treatment has less effect, so combination therapy is needed (Althof, 2002)

As a general handle in carrying out the sex therapy approach, what Immanuel recommends is as follows: 1) Overcoming problems with sexual dysfunction is a shared responsibility, sexual function disorders are interrelated disorders between partners, therefore couples must have responsibility the same to solve problems and improvements for the future, 2) Education and Information, this is very important because many sexual function disorders are caused by a lack of knowledge, the number of myths and misunderstandings that can cause anxiety, which ultimately causes sexual dysfunction, 3 ) Changes in attitude, a lot of sexual dysfunction because of the attitude that considers sexual behavior is very dirty, taboo and should not be discussed, which ultimately causes sexual dysfunction, 4) Relieve anxiety, often anxiety arises because one's sexual prognosis does not match with what they heard or expected, so that it must be alleviated and even eliminated, and 5) Levels of sexual communication and technique, sexual dysfunction is often caused by disturbances in communication with partners, frequent blaming, sensitivity, and closure with one another (Immanuel, 2013).

## Psychological Approach in Sexual Dysfunction

Since Freud era, more sexual disorders were associated with psychological disorders, based on Freud's theory of sexual dysfunction due to a person's history, especially psychosexual development. Impaired sexual function comes from a history of unresolved intrapsychic conflict and unconscious sexual conflict (Walker *et al.*, 2012). Based on this concept, the handling is through psychoanalytic psychological approaches. This approach aims to open a hidden intrapsychic conflict because it requires a long time.

Until around the 1960s, sexual dysfunction was handled by a psychoanalytic approach because the basic concepts of sexual function disorders were more seen as psychological disorders (Immanuel, 2013). Sex Therapy which is known now is a concept developed by Masters and Johnson around the 1970s, with shorter therapy time and more problem-focused. Then developed by Helen Kaplan who introduced new sex therapy, in this concept integrated between psychoanalytic and behavioral approaches. This concept is intensive therapy with a partner (husband and wife), with information about the anatomical structure of the human body along with its function, then proceed with counseling in accordance with what is needed. Then proceed with intervention directly in the form of exercises, including focus sensation (Immanuel, 2013).

After that Annon introduced one type of sex therapy which was abbreviated as the PLISSIT Model from Annon. This PLISSIT stands for Permission, Limited Information, Specific Suggestions and Intensive Therapy (Immanuel, 2013). However, very few sufferers of sexual dysfunction who want to be referred to sex therapy services, only about 10 percent want to be referred to a doctor who studies sex therapy. On the other hand, few workers have competencies in the field of sexuality. There is some approach to help sexual dysfunction such as combination medical and psychological therapy, the technique of mindfulness for women with complaints of arousal disorders an low sexual desire, internet sexual therapy and reconceptualization of genital pain and psychological interventions for women with these complaints (Althof *et al.*, 2010).

## Biological Therapy In Sexual Dysfunction

The development of handling sexual dysfunction depends on the progress of science in the sexual field. In around 1998 sexual knowledge developed with the discovery of PDE5i as a drug that can overcome erectile dysfunction in men. This development makes the concentration of the therapist's attention toward the biological approach so that psychological factors seem to be ruled out, everything can be overcome with medicine. This era is often referred to as the medicalization of sex (Goodwach, 2005).

Erectile dysfunction that was previously treated with training, with a vacuum that felt uncomfortable being a research center and study center with the development of PDE5i. With the establishment of sildenafil (PDE5i) as a therapy for erectile dysfunction disorders, about 90% of erectile dysfunction disorders are treated with PDE5i. Moreover, 5 years later, there were two other types of PDE5i, tadalafil, and vardenafil, which made all the attention to biology as a basis for therapy for sexual dysfunction.

Research for other sexual function disorders still refers to a biological approach, such as for premature ejaculation. Some studies use SSRIs to treat premature ejaculation. A study that collects articles on serotonin and premature ejaculation conclude that SSRIs (fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, and escitalopram) provide improvements in premature ejaculation (Moreland, 2005). A study using antidepressants mirtazapine and paroxetine found that paroxetine 20 mg daily for 6 weeks can improve premature ejaculation, while mirtazapine cannot improve premature ejaculation (Waldinger *et al.*, 2003). Giving SSRIs will inhibit reuptake at the presynaptic receptors and cause serotonin levels in the synapses to increase, which then bind to 5-HT 2C and 5-HT 1A receptors and slow ejaculation (Safarinejad and Hosseini, 2006)

An animal study given a combination of SSRIs and receptor antagonists can prolong ejaculation time (Looney *et al.*, 2005; Waldinger, 2007). To evaluate the effect of SSRIs, namely sertraline, a study was conducted by giving sertraline 50 mg to 22 patients with premature ejaculation, the results of the first week of 68.75% were improved (Balbay *et al.*, 1998). Fluoxetine as one of the SSRIs can significantly improve ejaculation (Lee, 1996). Giving fluoxetine one type of SSRI at a dose of 20 mg/day for 8 weeks turned out to provide an improvement of 68% (Novaretti *et al.*, 2002). The results of studies with various types of SSRIs have different results. With other types of SSRIs, namely paroxetine 20 mg, a measured study using Intravaginal Ejaculatory Latency Time (IELT) was also found to provide improved ejaculation, and no side effects were found (McMahon and Touma, 1999). With the provision of SSRI on demand, it was also studied

compared to the daily administration, the result of giving SSRIs on demand had a lower impact than the daily administration of improved ejaculation (Waldinger *et al.*, 2005)

A review of several studies using SSRI antidepressants to treat premature ejaculation found that there were 79 studies with various methodologies from 1943 to 2003. Differences in the effectiveness of various SSRIs were found based on their methodology, and paroxetine seen in therapy with pharmacotherapy, men are more focused on their erection than spur and feel the pleasure of themselves and their partners. Some couples feel their partners are more aroused with drugs compared to themselves. Some couples feel fear because their partners use drugs that can harm them, so they will focus more on watching their partner's reactions physically than feeling and enjoying sensations and pleasures. The other obstacle is that men will focus on their hopes that are not real, such as if they have had an erection repair they will be able to have sexual intercourse more often, if their expectations are not achieved, they will stop treatment (Althof, 2006)med to produce better results in improving ejaculation (Waldinger *et al.*, 2004).

### **Holistic Approach**

A study was conducted with 3 types of approaches, the first group was given psychotherapy with sessions every week for 6 months and sildenafil citrate 50 mg on demand, the second group was only given sildenafil citrate 50 mg on demand for 6 months, and the third group was given psychotherapy alone weekly session for 6 months. The result is that improvements in baseline data occurred in all groups, but significant improvements occurred in the first group (Melnik and Abdo, 2005). It was explained that psychotherapy can improve patients' understanding of emotions, help patients strengthen the patient's commitment to change the process, become more deeply involved, also make it more realistic and positive sexual expectations (Althof, 2006)

In another study by Phelps, he put pressure on the psychoeducation intervention session. The first group received combination therapy between sildenafil and psychoeducation interventions for 60-90 minutes, and the second group was only given sildenafil. The psychoeducation includes sexual function, an explanation of expectations of therapy, and the provision of training. After 24 weeks, the two groups showed significant improvement, but the satisfaction score in the psychoeducation group was higher than the sildenafil group alone.

The research was conducted to evaluate the effectiveness of psychosocial interventions in erectile dysfunction compared to oral drugs, local injections, vacuum, and various psychosocial interventions such as the psychoeducation method, psychotherapy or both. The researchers concluded that the therapy group and sildenafil compared with sildenafil alone, patients with group therapy and sildenafil showed better improvements in sexual intercourse success and fewer dropouts. The psychotherapy group also provided significant improvements compared to Sildenafil alone (Melnik *et al.*, 2007)

### **CONCLUSION**

In the midst of advances in the field of treatment of sexual function disorders, so that patients with sexual function disorders can be handled properly. It must always be borne in mind that humans are creatures that respond holistically, so the handling of patients with sexual dysfunction must be done holistically. In this case, the sex therapy approach as part of psychotherapy needs to be continuously improved so that it can carry out optimal treatment. Thus sufferers of sexual function disorders can be helped thoroughly, not only to improve sexual function disorders but to improve the quality of sexual relations and make family functions harmonious for the mental health of husbands, wives, and children.

### **REFERENCES**

- [1]. Althof, S. E. (2006). Sexual therapy in the age of pharmacotherapy. *Annual Review of Sex Research*, 17(1), 116-131. <https://www.tandfonline.com/doi/abs/10.1080/10532528.2006.10559839>
- [2]. Althof, S. E. (2010). What's new in sex therapy (CME). *The journal of sexual medicine*, 7(1), 5-13. <https://doi.org/10.1111/j.1743-6109.2009.01433.x>
- [3]. Balbay, M. D., Yildiz, M., Şalvarci, A., Özsan, Ö., &Özbek, E. (1998). Treatment of premature ejaculation with sertraline. *International urology and nephrology*, 30(1), 81-83. <https://doi.org/10.1007/BF02550283>

- [4]. Balon, R. (2006). SSRI-associated sexual dysfunction. *American Journal of Psychiatry*, 163(9), 1504-1509. <https://ajp.psychiatryonline.org/doi/abs/10.1176/ajp.2006.163.9.1504>
- [5]. Bancroft, J. (2009). Human sexuality and its problems. Churchill Livingstone.
- [6]. Goodwach, R. (2005). Fundamentals of Theory and Practice Revisited: Sex Therapy: Historical Evolution, Current Practice. Part I. *Australian and New Zealand Journal of Family Therapy*, 26(3), 155-164. <https://doi.org/10.1002/j.1467-8438.2005.tb00663.x>
- [7]. Hatzimouratidis, K., & Hatzichristou, D. (2007). Sexual dysfunctions: classifications and definitions. *The journal of sexual medicine*, 4(1), 241-250. <https://doi.org/10.1111/j.1743-6109.2007.00409.x>
- [8]. Hayes, R. D., Bennett, C. M., Fairley, C. K., & Dennerstein, L. (2006). Epidemiology: What can prevalence studies tell us about female sexual difficulty and dysfunction?. *The journal of sexual medicine*, 3(4), 589-595. <https://doi.org/10.1111/j.1743-6109.2006.00241.x>
- [9]. Immanuel, K. (2013). *Critique of pure reason*. Hardpress Limited.
- [10]. Aarti tarun patel, pooja rasiklal modiya, gajanan shinde#, rakesh patel.. "formulation and characterization of long circulating liposomes of anti fungal drug ." *International Journal of Pharmacy Research & Technology* 8.2 (2018), 32-42.
- [11]. Zghair, A.N., Sharma, R., Alfaham, M., Sharma, A.K. "Upregulation of BRCA1, ERBB2 and TP53 marker genes expression in breast cancer patients (2018)", *International Journal of Pharmaceutical Research*, 10 (2), pp. 147-154.
- [12]. Lewis, R. W., Fugl-Meyer, K. S., Bosch, R., Fugl-Meyer, A. R., Laumann, E. O., Lizza, E., & Martin-Morales, A. (2004). Epidemiology/risk factors of sexual dysfunction. *The journal of sexual medicine*, 1(1), 35-39. <https://doi.org/10.1111/j.1743-6109.2004.10106.x>
- [13]. Looney, C., Thor, K. B., Ricca, D., & Marson, L. (2005). Differential effects of simultaneous or sequential administration of paroxetine and WAY-100,635 on ejaculatory behavior. *Pharmacology Biochemistry and Behavior*, 82(3), 427-433. <https://doi.org/10.1016/j.pbb.2005.09.014>
- [14]. McMahon, C. G., & Touma, K. (1999). Treatment of premature ejaculation with paroxetine hydrochloride. *International journal of impotence research*, 11(5), 241. <https://doi.org/10.1038/sj.ijir.3900415>
- [15]. Melnik T and Abdo C, 2005. Psychogenic Erectile Dysfunction: Comparative Study of Three Therapeutic Approaches. *Journal of Sex and Marital Therapy*, 31: 243-256.
- [16]. Moreira Jr, E. D., Kim, S. C., Glasser, D., & Gingell, C. (2006). EPIDEMIOLOGY: Sexual Activity, Prevalence of Sexual Problems, and Associated Help-Seeking Patterns in Men and Women Aged 40–80 Years in Korea: Data from the Global Study of Sexual Attitudes and Behaviors (GSSAB). *The journal of sexual medicine*, 3(2), 201-211. <https://doi.org/10.1111/j.1743-6109.2006.00210.x>
- [17]. Moreland, A. J., & Makela, E. H. (2005). Selective serotonin-reuptake inhibitors in the treatment of premature ejaculation. *Annals of Pharmacotherapy*, 39(7-8), 1296-1301. <https://doi.org/10.1345%2Faph.1E069>
- [18]. Nicolosi, A., Laumann, E. O., Glasser, D. B., Brock, G., King, R., & Gingell, C. (2006). Sexual activity, sexual disorders and associated help-seeking behavior among mature adults in five anglophone countries from the Global Survey of Sexual Attitudes and Behaviors (GSSAB). *Journal of Sex & Marital Therapy*, 32(4), 331-342. <https://doi.org/10.1080/00926230600666469>
- [19]. Novaretti, J. P., Pompeo, A. C., & Arap, S. A. M. I. (2002). Selective serotonin re-uptake inhibitor in the treatment of premature ejaculation. *Braz J Urol*, 28(2), 116-122.
- [20]. Pangkahila, W. 2003. Mitos dan Gangguan Seksual. Kompas Cyber Media. Retrieved at <http://64.203.71.11/kesehatan/news/0306/25/111235html>. accessed in July 2014.
- [21]. Payne, R. E., & Sadovsky, R. (2007). Identifying and treating premature ejaculation: importance of the sexual history. *Cleveland Clinic journal of medicine*, 74(3), S47. [https://mdedge-files-live.s3.us-east-2.amazonaws.com/files/s3fs-public/issues/articles/content\\_74\\_Suppl\\_3\\_SI-47.pdf](https://mdedge-files-live.s3.us-east-2.amazonaws.com/files/s3fs-public/issues/articles/content_74_Suppl_3_SI-47.pdf)
- [22]. Rosen, R. C., Seidman, S. N., Menza, M. A., Shabsigh, R., Roose, S. P., Tseng, L. J., ... & Siegel, R. L. (2004). Quality of life, mood, and sexual function: a path analytic model of treatment effects in men with erectile

- dysfunction and depressive symptoms. *International journal of impotence research*, 16(4), 334. <https://www.nature.com/articles/3901197>
- [23]. Safarinejad, M. R., & Hosseini, S. Y. (2006). Pharmacotherapy for premature ejaculation. *Current Drug Therapy*, 1(1), 37-46. <https://doi.org/10.2174/157488506775268434>
- [24]. Waldinger, M. D. (2007). Premature ejaculation. *Drugs*, 67(4), 547-568. <https://doi.org/10.2165/00003495-200767040-00005>
- [25]. Waldinger, M. D., Schweitzer, D. H., & Olivier, B. (2005). On-demand SSRI treatment of premature ejaculation: pharmacodynamic limitations for relevant ejaculation delay and consequent solutions. *The journal of sexual medicine*, 2(1), 121-131. <https://doi.org/10.1111/j.1743-6109.2005.20112.x>
- [26]. Walker, L. M., & Robinson, J. W. (2012). Back to the basics: Origins of sex therapy, sexual disorder and therapeutic techniques.
- [27]. Wiederman, M. W. (1998). The state of theory in sex therapy. *Journal of Sex Research*, 35(1), 88-99. <https://doi.org/10.1080/00224499809551919>